Patient Name/Adressograph

Diabetes Discharge Prescription

Allergies:	QTY	REF
Insulin:		
" Basal Insulin" (specify insulin type)-------------------sig--------------- **"Mealtime Insulin"(specify insulin type)----------------** --------------------- sig: Inject sub Q three times daily before each meal **--------**units **PLUS** Correction Scale selected below.	1 Vial	
Physician to designate insulin Correction Dose :		
Correction Scale: **Specify insulin type**		
(correction scale table below)	------ Vial	
Basal Insulin (Specify type) ------------------ sig:	-------vial	
Short acting/ Rapid acting Insulin (Specify type)------------------sig:	-------vial	
Oral Diabetes Medication:		
-------------mg sig:---------------		
-------------mg sig:---------------		
-------------mg sig:---------------		
------------- mg sig:----------------		
-------------mg sig:---------------		
-------------mg sig:---------------		
OTHER:		
Insulin Syringes: (specify type)-----------------------	Box of ------	
Alcohol Wipes	Box of ------	
Glucose Tablets	-------- size	
Glucose get 15	---------tube	
-------------- Test Strips or generic(Testing------------ times daily)	-------------	
Lancets (Testing ---------- times daily)	-------------	
****This prescription NOT VALID for Controlled Substances*****		

	MILD Insulin Sensitive Lean/Elderly/Renal	MODERATE Average weight	AGGRESSIVE Insulin Resistant Infection/ Obese/ Steroids	CUSTOM	BG mg/dL
151-200	1 Units	2 Units	4 Units	Units	151-200
201-250	2 Units	3 Units	5 Units	Units	201-250
251-300	3 Units	5 Units	7 Units	Units	251-300
301-350	4 Units	6 Units	8 Units	Units	301-350
351-400	5 Units	7 Units	10 Units	Units	351-400
>400	Call MD	Call MD	Call MD	Call MD	>400

Physician Printed Name Signature

Date

Address

Telephone

License

DEA Number